DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICAID AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **04-016**

2. STATE: **Ohio**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~**March 1,** 2005~~
July 1,

5. TYPE OF PLAN MATERIAL *(Check One)*:

☒ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932(a)(1)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY **2005** $ **659,282**
b. FFY **2006** $ **750,758**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F
Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: **This amendment requests CMS approval to transfer authority of the State of Ohio's PremierCare program from a 1915(b) waiver to a State Plan Amendment (SPA).**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's office has delegated review to the Director of ODJFS

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

14. TITLE: Director

15. DATE SUBMITTED: 12/10/04

16. RETURN TO:
Becky Jackson
ODJFS/BHPP
30 E. Broad St, 27th Floor
Columbus, OH 43215-3414

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **12/15/04**

18. DATE APPROVED: 3/14/05

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2005

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: **Cheryl A. Harris**

22. TITLE: **Associate Regional Administrator Division of Medicaid and Children's Health**

23. REMARKS:

RECEIVED
DEC 15 2004
DMCH - ARA

FORM HCFA-179 (07-92)

State:

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of *Ohio* enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

_X_ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____ i. fee for service;
_X_ ii. capitation;
____ iii. a case management fee;
_X_ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

The MCO rate methodology is outlined in the attached document. The attached spreadsheets are the different appendices which are referenced in the methodology.

1905(t)
42 CFR 440.168

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's

Citation	Condition or Requirement
42 CFR 438.6(c)(5)(iii)(iv)	case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. ____vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* *This purpose of this SPA is to transfer the authority of the State of Ohio's comprehensive, full-risk managed care program known as PremierCare, from a 1915(b) waiver to a SPA. The Ohio Department of Job and Family Services (ODJFS) will therefore continue to convene community-based meetings of key stakeholders to assure ongoing public involvement under the SPA. Stakeholders attending these meetings include: local providers, consumer advocates, MCOs, county departments of job and family services, local health departments, and other social service agencies.* *The statewide Medical Care Advisory Committee has also served as a forum for discussion of the managed care program and related issues.*

Citation	Condition or Requirement

In addition to these ongoing groups, ODJFS has convened ad hoc "roundtables" for the discussion of specific issues such as dental access, the prudent layperson standard, and the implementation of the Balanced Budget Act. Depending on the topic, attendees of these meetings are associations and managed care organizations with the goals of sharing concerns and identifying best practices.

Other forums for stakeholder involvement include meetings with the Ohio Department of Health, Bureau of Children with Medical Handicaps; meetings with provider associations, and technical assistance sessions with MCOs and county departments of job and family services.

1932(a)(1)(A)

5. The state plan program will___/will not _X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory _X_ / voluntary _X_ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory)
   Cuyahoga, Lucas, Stark, and Summit Additional counties may be added in the future.

   ii. county/counties (voluntary)
   Clermont, Greene, Pickaway, Warren, and Wood..

   Butler, Clark, Franklin, Hamilton, Lorain, and Montgomery[1].

   Additional counties may be added in the future.

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

[1] *Butler, Clark, Franklin, Hamilton, Lorain, and Montgomery are Preferred Option counties. Eligible consumers in Preferred Option counties choose between Medicaid FFS and an MCO. Consumers who do not choose the FFS option are enrolled in the MCO. Enrollees in Preferred Option counties are able to disenroll without cause at any time and choose the FFS option.*

State:

Citation		Condition or Requirement
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1.	__X__ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2.	____The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	__X__ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	__X__ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	__X__ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	__X__ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	__X__ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)	1.	List all eligible groups that will be enrolled on a mandatory basis. *The following groups are enrolled on a mandatory basis in selected counties: Section 1931 Children and Adults and related poverty level populations,*

Citation	Condition or Requirement
	including pregnant women and children (TANF/AFDC); and Title XXI CHIP children.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ____Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. __X__ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. __X__ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. __X__ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. __X__ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* *These are children served through the Ohio Department of Health, Bureau of Children with Medical Handicaps (BCMH). BCMH administers Ohio's Title V program.*
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: __X__ i. program participation, ____ ii. special health care needs, or ____ iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. __X__ i. yes ____ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; *Eligibility database and self-identification.* ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; *Eligibility database.* iii. Children under 19 years of age who are in foster care or other out-of-home placement; *Eligibility database and self-identification.* iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Eligibility database and self-identification.

1932(a)(2)

42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

Although under our current system we are unable to identify special needs children prior to their receiving a notice informing them of their need to enroll, exempted groups identified by the selection services contractor (enrollment broker) during the enrollment interview will be advised of their option not to enroll in a plan.

Further, we will make ongoing efforts to notify exempted groups that, if they are enrolled in a plan and do not wish to remain enrolled, they can disenroll from the MCO and receive their health care benefit through the traditional Medicaid fee-for-service (FFS) program. First, language will be added to the MCO Consumer Guide specific to the enrollment options for children in exempted groups. The Consumer Guide is distributed prior to the annual open enrollment month in each county and provided to consumers throughout the year by Ohio's enrollment broker. Second, all MCOs in mandatory enrollment counties will be required to include a notice in their new member packet thoroughly explaining that MCO enrollment is always voluntary for children in exempted groups and the procedures for disenrollment. Finally, MCOs will be required to periodically provide general information on children with special needs enrollment options through their member handbooks, newsletters, etc.

1932(a)(2)

42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients who are also eligible for Medicare.

Recipients who are also eligible for Medicare will be identified based on their eligibility category.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service

or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Indians are identified by self identification.

42 CFR 438.50 F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

- *Recipients who are homeless.*

42 CFR 438.50 G. List all other eligible groups who will be permitted to enroll on a voluntary basis

H. Enrollment process.

Counties served by MCOs fall into one of three categories: voluntary, mandatory, or preferred option. In counties with two or more MCOs, enrollment in managed care is mandatory. ODJFS requested and received approval from CMS to operate a preferred option program in selected Ohio counties served by only one MCO. Eligible consumers in preferred option counties choose between FFS and the MCO. Consumers who do not actively choose the FFS option are enrolled in the MCO. Enrollees in preferred option counties are able to disenroll without cause at any time and choose the FFS option. There are no open enrollment or lock-in restrictions in preferred option counties.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

The default enrollment process is made based on the goal of preserving the existing provider-patient relationship. In order to ensure continuity of care, previously MCO-enrolled recipients are returned to the same MCO, except if the disenrollment was recipient initiated. For members not previously enrolled, Medicaid FFS paid claims having primary care service codes are extracted for each MCO eligible and used to determine the most recent and regular primary care visit. The member is then assigned to the MCO that has this provider on their panel.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

ODJFS contracts with MCOs, not providers directly. We attribute part of the success of the managed care program to the fact that MCOs include the traditional FFS providers in their panel, as well as other providers that do not participate in the FFS system. Also, we require MCOs to either contract with all Federally Qualified Health Centers (FQHCs) in the service area or allow their members open access to any non-contracting FQHCs.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in